

FORM S.F. 137 DOT EF 6/05	 STATE OF WASHINGTON VEHICLE ACCIDENT REPORT
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Date of Accident (MM/DD/YY)	
Time	<input type="checkbox"/> AM <input type="checkbox"/> PM

INSTRUCTIONS: This report must be mailed within two working days to the following 2 offices:

- ① Office of Financial Management
 Risk Management Division
 300 General Administration Building
 Post Office Box 41027, MS: 41027
 Olympia, Washington 98504-1027

② Safety/Risk Management
 Office of Reporting Agency

This report cannot be submitted electronically (via e-mail or fax)

STATE EMPLOYEE	Name		Age	Employing Agency		Position		
	Business Address			Zip	Business Phone	Was vehicle being used on Official State Business? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Operator's License No.		License Restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Indicate		Have you had a previous accident while driving on state business? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	License No.	Year	Make	Body Type	Where Located		No. of Passengers Est. Repair Cost	
VEHICLE NO. 1	Owning Agency		Describe Damages Fully (Parts, type and extent of damage)					
	If Privately Owned, Name and Address of Owner (If State Owned, Equipment No. Only)						Insurer	
OTHER VEHICLES	Owner Car No. 2		Phone		Owner Car No. 3		Phone	
	Address		City	Zip	Address		City Zip	
	Driver		Age	Phone	Driver		Age Phone	
	Address		City	Zip	Address		City Zip	
	Driver's License No.		Vehicle License No.		Driver's License No.		Vehicle License No.	
	Vehicle Make		Year	Body Type	Vehicle Make		Year Body Type	
	Name of Passengers				Name of Passengers			
	Repair Cost		Describe Damage			Repair Cost		Describe Damage
	Insurance Company			Policy No.		Insurance Company		Policy No.
	OTHER PROPERTY	What was Damaged?						Repair Cost
Name and Address of Owner						City Zip Phone		
INJURED PARTIES	Name and Address				Extent of Injury	Age	Veh. 1 Veh. 2 Veh. 3 Ped.	
WITNESSES	Name		Address		City	Zip	Phone	
OTHER	Police Investigate? <input type="checkbox"/> Yes <input type="checkbox"/> No		Which Division (Sheriff, WSP, City)		Citation Issued? <input type="checkbox"/> Yes <input type="checkbox"/> No Issued To <input type="checkbox"/> You <input type="checkbox"/> Veh. 2 <input type="checkbox"/> Veh. 3		Have you filed Financial Responsibility Form WSP 161 As Required by Law? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Location		Or Near Intersection of	
City/County		Type of Accident	<input type="checkbox"/> Front to Rear <input type="checkbox"/> Head-On <input type="checkbox"/> Parked Car <input type="checkbox"/> Pedestrian <input type="checkbox"/> Broadside <input type="checkbox"/> Sideswipe <input type="checkbox"/> Bike - Car <input type="checkbox"/> Hit Object

Information Regarding Accident	No. 1, Your Vehicle	No. 2, Other Party (Name)	No. 3, Other Party (Name)
1. If pedestrian, where was he/she (crosswalk, etc.)?			
2. Road conditions (dry, glare, icy, rain, snow, etc.)? (Gravel, blacktop, etc.)			
3. At what distance was danger first noticed?			
4. Speeds at time danger was first noticed?			
5. Speeds at time of accident?			
6. What warning signals were given?			
7. Obstruction to vision (weather and other)?			
8. Lights On? Wipers On? Windows Fogged?			
9. Had any party been drinking? Who?			

Describe in Detail What Happened (Use additional paper if necessary)

☐ Straight Road
☐ Curve - R or L
☐ Level

☐ Hillcrest
☐ Uphill
☐ Downhill

☐ One Lane
☐ One and One-Half Lane
☐ Two Lane or Four Lane

Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.

IMPORTANT
If street or view was obstructed in any way, indicate where and how; also indicate any street car or tracks and traffic signals or signs.

Indicate points of compass
N. E. S. W.

Mark Damaged Areas

Signature (Driver)	Date	Signature (Supervisor)	Date
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